



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Gerald Halaby, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-2106-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = \$350.00
IR – UPPER EXTREMITY W/ROM = \$300.00
IR – NERVE SYSTEM = \$150.00
TTL = \$800.00"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The designated doctor rated one area the upper extremity but billed two units: one for the upper extremity and one for the ulnar nerve in the upper extremity. Texas Mutual paid \$350.00 for the MMI exam and \$300.00 for the IR of the upper extremity."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------------------|-------------------|------------|
| May 19, 2015 | Designated Doctor Examination | \$150.00 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers compensation jurisdictional fee schedule adjustment.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that:

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.
- (D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.
 - (i) Non-musculoskeletal body areas are defined as follows:
 - (I) body systems;
 - (II) body structures (including skin); and,
 - (III) mental and behavioral disorders.
 - (ii) **For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides [emphasis added]...**
 - (iv) When there is no test to determine an IR for a non-musculoskeletal condition:
 - (I) **The IR is based on the charts in the AMA Guides [emphasis added].** These charts generally show a category of impairment and a range of percentage ratings that fall within that category.
 - (II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.
 - (III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.
 - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the impairment ratings provided by the requestor were all taken from the musculoskeletal chapter of the AMA Guides, upper extremities section. The documentation supports that the requestor performed an impairment rating that included a full physical examination with range of motion. Therefore, the correct MAR for this examination is \$300.00.

2. The total MAR for the disputed services is \$650.00. The insurance carrier paid \$650.00. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

| | | |
|-----------|--|-----------------------|
| _____ | <u>Laurie Garnes</u> | <u>April 21, 2016</u> |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.